

STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

PHARMACY

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

Address of Record: The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

SUPPORTING DOCUMENTS AND FEES:

In addition to submitting a completed application, complete the following:

1. Submit a **\$200.00** non-refundable application-processing fee for a pharmacy license, made payable to “DOPL.”
2. Submit an additional **\$90.00** non-refundable application-processing fee for a Utah Controlled Substance License — if the pharmacy will be dispensing controlled substances within or into Utah.

NOTE: If you are applying for a pharmaceutical license and a controlled substance license, you can pay the \$290.00 fees in a single check or money order.

3. If the facility seeking licensure intends to dispense controlled substances in Utah **to any person** other than an inpatient in a licensed health care facility, the pharmacist-in-charge must complete the “Controlled Substance Database Questionnaire” found on page 19 of this application. *(This requirement applies to both in-state and out-of-state facilities.)*
4. If applying for **Class A, retail pharmacy** licensure additionally complete the “New Opening Pharmacy Self-Inspection Report for Class A (Retail) Pharmacies” found on pages 21 – 24 of this application.

NOTE: The Class A Pharmacy Self Inspection Evaluation is provided to allow DOPL to

more quickly expedite the processing of your Retail Pharmacy license. Please complete the form and submit it with your pharmacy application. A live inspection will also be conducted by the Investigative staff within a short time after your license has been issued. A staff member will call you to set up a convenient time for the live inspection.

5. If applying for **Class B, branch pharmacy** licensure, additionally submit the following:
 - ☐ A formulary of prescription drugs to be prepackaged, including name of drug, dosage strength, and dosage units.
 - ☐ A summary of your operating protocol, including the conditions under which the drugs will be stored, used, and accounted for.
 - ☐ A summary of the method by which drugs will be transported from the parent pharmacy to the branch pharmacy and accounted for by the branch pharmacy.
 - ☐ A description of how your records will be kept and audits and inventories dealt with in regard to the formulary, drugs sent and received, drugs dispensed, frequency and method of inventories and controls.
6. If applying for **Class D, out-of-state mail order pharmacy** licensure, additionally submit the following:
 - ☐ A certified letter from the licensing authority of the state in which the pharmacy is located attesting to the fact that the pharmacy is licensed in good standing and is in compliance with all laws and regulations of that state.
 - ☐ A copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records, and operations.
 - ☐ A copy of a current license for the Pharmacist-in-Charge.

ADDITIONAL IMPORTANT INFORMATION:

1. **Laws and Rules:** You are required to understand all Utah laws and rules pertaining to your practice. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov:
 - ☐ Division of Occupational & Professional Licensing Act
 - ☐ General Rules of the Division of Occupational & Professional Licensing
 - ☐ Pharmacy Practice Act
 - ☐ Pharmacy Practice Act Rules
 - ☐ Utah Controlled Substances Act
 - ☐ Utah Controlled Substances Act Rules

2. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to www.dopl.utah.gov to ensure you have the most recent version of these documents.
3. **Controlled Substance License/DEA Registration:** You must hold a Utah controlled substance license **and** a DEA registration to administer, possess, or prescribe a controlled substance in your practice of medicine in Utah. For DEA registration information, contact the Drug Enforcement Administration, Salt Lake District Office, 348 East South Temple, Salt Lake City, UT 84088. Telephone (801) 524-4389.
4. **Board Interview:** An applicant may be required to appear before the State Board of Pharmacy. After your application has been received, you will be contacted to schedule an interview if required. The Board usually meets the fourth Tuesday of each month.
5. **Pharmacy Inspection:** As a requirement for licensure, all in-state facilities must pass an inspection. DOPL will schedule an inspection of the facility. All out-of-state mail order pharmacies must include a copy of the most recent inspection conducted by the state in which the dispensing facility is located.
6. **Patient Counseling:** A pharmacist or pharmacy intern in a retail pharmacy, out-of-state mail order pharmacy, or institutional pharmacy shall orally offer to counsel a patient or a patient's agent in a personal face-to-face discussion with respect to each prescription drug dispensed, if the patient or patient's agent:
 - ☐ Delivers the prescription in person to the pharmacist, pharmacy intern, or pharmacy technician with instructions that the dispensed prescription drug be mailed or otherwise delivered to the patient outside of the pharmaceutical facility.
 - OR
 - ☐ Receives the drug in person at the time it is dispensed at the pharmaceutical facility.

A pharmacist or pharmacy intern in a retail pharmacy, out-of-state mail service pharmacy, or institutional pharmacy shall provide each patient, in writing, competent counseling, and shall provide the patient with a toll-free telephone number by which the patient may contact a competent pharmacist at the dispensing pharmacy during normal business hours and receive oral counseling, with respect to each prescription drug dispensed if the patient provides or the prescription is otherwise provided to the pharmaceutical facility by a means other than personal delivery, and the dispensed prescription drug is mailed or otherwise delivered to the patient outside of the pharmaceutical facility.
7. **Controlled Substance Database:** Section 58-37-7.5 of the Utah Controlled Substances Act requires pharmacies to report data regarding every prescription for a controlled substance dispensed in Utah. Once licensed, you will be contacted by the Database Manager who will provide you with further information and instructions.

8. **Wholesaler/Distributor:** Utah licensure is required if drugs are stored in or distributed from any facility physically located in Utah. If there are no facilities in Utah, but drugs are shipped into Utah, licensure, in good standing, is required in the state of domicile, but Utah licensure is not required.

9. **License Renewal:** All pharmacy licenses expire September 30 of each odd-numbered year. Additionally, your pharmacy controlled substance license will expire at the same time as the pharmacy license and will also need to be renewed. Unlike many other states, Utah's license renewal schedule **is not** based on the licensee's date of initial licensure. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years.

Additionally, the fee paid with this application for licensure is an application-processing fee only. It does not include a renewal fee. Each licensee is responsible to renew licensure **PRIOR** to the expiration date shown on the current license. Approximately two months prior to the expiration date shown on the license, renewal information is disseminated to each licensee's last address of record, as provided to DOPL.

10. **Name, Location, or Ownership Change:** If you change the name of your agency, if its location changes, or if there is a change in ownership, you must submit a new application and new licensure fees.

11. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at www.dopl.utah.gov.

12. **Mail Complete Application to:**

By U.S. Mail

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

13. **Telephone Numbers:** (801) 530-6628

(866) ASK-DOPL – Toll-free in Utah
(866) 275-3675

14. **Fax Number:** (801) 530-6511

APPLICATION FOR LICENSURE

The business legal name is the name that will appear on the license, normally the name registered with the Utah Division of Corporations. If there is a fictitious business name (*doing business as*), list that name also, e.g., XYZ Corporation dba XYZ Pharmacy. If the applicant is not required to register with the Division of Corporations, it is the name of the pharmacy/facility where licensed activity is to be conducted. The physical location and mailing address is the actual location where licensed activity will be conducted and the address where DOPL will send all mail.

LICENSE(S) APPLYING FOR: (Check all that apply.)

CLASS A:

☐ Retail

CLASS B:

- ☐ Closed Door
- ☐ Hospital Clinic
- ☐ Methadone Clinic
- ☐ Nuclear
- ☐ Branch
- ☐ Hospice Facility
- ☐ Veterinarian Pharmaceutical Outlet
- ☐ Pharmaceutical Administration Facility
- ☐ Sterile Products Preparation

CLASS C:

- ☐ Pharmaceutical Wholesaler/Distributor
- ☐ Pharmaceutical Manufacturer

CLASS D:

- ☐ Out-of-State Mail Order

CLASS E:

- ☐ Analytical Laboratory
- ☐ Medical Gases
- ☐ Durable Medical Equipment
- ☐ Other: _____
- ☐ Utah Controlled Substance License

NAME OF PHARMACY: _____

PHYSICAL LOCATION AND MAILING ADDRESS:

Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax Number: _____

Email: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: ____/____/____

Approved By: _____

Date License/Certificate Denied: ____/____/____

Denied By: _____

Reason for Denial/Other Comments: _____

LOCAL CONTACT PERSON FOR LICENSING PURPOSES:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

DISCLOSURE OF NATURE OF BUSINESS:

(Please be specific. Use additional sheets if necessary.)

COMPLIANCE WITH UTAH LAWS AND RULES

All owners, officers, managers, pharmacists, and pharmacy technicians associated with or employed by the applicant understand that it is their continuing responsibility to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Signature of Responsible Party: _____ Date: ____/____/____

**LOCAL CONTACT PERSON FOR LICENSING PURPOSES:
REASON FOR APPLICATION:**

Answer “yes” or “no.”

☐ Yes ☐ No New Facility

☐ Yes ☐ No Change of Name

☐ Yes ☐ No Change of Location

☐ Yes ☐ No Change of Ownership

CHANGE OF NAME:

Name as Formerly Licensed: _____

Utah Pharmacy License Number: _____

Utah Controlled Substance License Number: _____

Effective Date of Name Change: ____/____/____

CHANGE OF LOCATION OR REMODELING:

Utah Pharmacy License Number: _____

Utah Controlled Substance License Number: _____

Old Address or Relocation within the Facility: _____

Proposed Date of Relocation or Remodeling: ____/____/____

CHANGE OF OWNERSHIP OR TAKEOVER OF EXISTING PHARMACY:

Name as Formerly Licensed: _____

Utah Pharmacy License Number: _____

Utah Controlled Substance License Number: _____

Effective Date of Ownership Change: ____/____/____

On the following pages, complete the ONE section that pertains to the type of facility for which you are seeking licensure.

CLASS A: RETAIL

Name of Pharmacist-In-Charge: _____

State of Licensure: _____ Pharmacist License Number: _____

Controlled Substance License Number: _____

Address: _____

Telephone Number: _____

**CLASS B: CLOSED DOOR, HOSPITAL CLINIC, NUCLEAR, BRANCH, HOSPICE,
VETERINARY PHARMACUETICAL OUTLET, OR STERILE PRODUCT**

Name of Pharmacist-In-Charge: _____

State of Licensure: _____ Pharmacist License Number: _____

Controlled Substance License Number: _____

Address: _____

Telephone Number: _____

**CLASS B: MEHTADONE CLINIC OR PHARMACEUTICAL ADMINISTRATION
FACILITY**

Name of Consulting Pharmacist: _____

State of Licensure: _____ Pharmacist License Number: _____

Controlled Substance License Number: _____

Address: _____

Telephone Number: _____

CLASS B: NUCLEAR PHARMACY

Answer “yes” or “no.”

☐ Yes ☐ No Is the Pharmacist-In-Charge certified by the Board of Pharmaceutical Specialists in Nuclear Pharmacy or have equivalent classroom and laboratory training and experience as required by the Utah Radiation Control Rules?

☐ Yes ☐ No Does the pharmacy have a current Utah Radioactive Materials License?

CLASS B: BRANCH PHARMACY

(To be completed by the pharmacist-in-charge of the parent pharmacy. Use additional sheets wherever necessary.)

Physical Address of the Branch Pharmacy: _____

Identify the distance between or from all nearby alternative pharmacies and all other factors affecting access of persons in the area to alternative pharmacy resources.

Describe the facility in which the branch pharmacy is to be located.

STAFF: List all persons who will dispense prescription drugs at the branch pharmacy.

Name: _____ Position: _____

License Classification: _____ License Number: _____

Name: _____ Position: _____

License Classification: _____ License Number: _____

Name: _____ Position: _____

License Classification: _____ License Number: _____

(Continued on the next page.)

PARENT PHARMACY FOR CLASS B BRANCH PHARMACY:

Name: _____

Address: _____

Telephone Number: _____

Utah Pharmacy License Number: _____

Utah Controlled Substance License Number: _____

Parent Pharmacy Supervising Pharmacist Willing to Assume Responsibility as Pharmacist-In-Charge for the Branch Pharmacy:

Name: _____

Telephone Number: _____

Utah Pharmacist License Number: _____

Utah Controlled Substance License Number: _____

Answer “**yes**” or “**no**.”

☐ Yes ☐ No A formulary of prescription drugs to be prepackaged, including name of drug, dosage strength, and dosage units, **is included with this application.**

☐ Yes ☐ No A summary of operating protocol, including the conditions under which the drugs will be stored, used, and accounted for, **is included with this application.**

☐ Yes ☐ No A summary of the method by which drugs will be transported from the parent pharmacy to the branch pharmacy and accounted for by the branch pharmacy, **is included with this application.**

☐ Yes ☐ No A description of how records will be kept and audits and inventories dealt with in regard to: the formulary, drugs sent and received, drugs dispensed, frequency and method of inventories and controls, **is included with this application.**

CLASS C: PHARMACEUTICAL WHOLESALER, DISTRIBUTOR, OR MANUFACTURER

Name of Responsible Officer/Management Employee: _____

List All Trade or Business Names Used: _____

Complete for **each facility** used for storage, handling, distribution and/or manufacturing of prescription drugs. Use additional sheets if necessary:

1. Contact Person: _____

Phone: _____ Social Security Number: _____

Facility Name: _____

Facility Address: _____

2. Contact Person: _____

Phone: _____ Social Security Number: _____

Facility Name: _____

Facility Address: _____

3. Contact Person: _____

Phone: _____ Social Security Number: _____

Facility Name: _____

Facility Address: _____

FDA Number (*manufacturers only*): _____

List past experience in the manufacture or distribution of prescription drugs, including controlled substances. (*Use additional sheets if necessary.*)

CLASS D: OUT-OF-STATE MAIL ORDER

State in Which Facility is Located: _____

Pharmacy License Number: _____

Category or Classification of License: _____

Pharmacist in Charge: _____

Pharmacist in charge License Number: _____

Date of Last Inspection by Licensing Authority: ____/____/____ (mm/dd/yyyy)

Patient Toll Free Contact Telephone Number: _____

Availability for Patient Counseling: Days: _____ Hours: _____

Answer “yes” or “no.”

☐ Yes ☐ No A certified letter from the licensing authority of the state in which the pharmacy is located attesting to the fact that the pharmacy is licensed in good standing and is in compliance with all laws and regulations of that state, is **included with this application**.

☐ Yes ☐ No A copy of the Pharmacist in charge current license **is attached**.

☐ Yes ☐ No A copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records, and operations, is **included with this application**.

☐ Yes ☐ No The pharmacy provides each patient with written competent counseling.

☐ Yes ☐ No The pharmacy provides each patient with a toll-free telephone number by which the patient may contact a competent pharmacist at the pharmacy during normal business hours to receive oral counseling.

AFFIDAVIT

I, _____, affirm that _____ Pharmacy will cooperate with all lawful requests and directions of the licensing authority of the state of domicile relating to the shipment, mailing, or delivery of dispensed legend drugs into Utah.

Signature: _____ Date: ____/____/____

CLASS E: ANALYTICAL LABORATORY

Laboratory Director Name: _____

Lab Director Address: _____

PROTOCOL: Describe how prescription drugs will be purchased, stored, used, and accounted for. *(Use additional sheets if necessary.)*

CLASS E: MEDICAL GASES

1. Contact Person: _____

Phone: _____ Social Security Number: _____

Facility Name: _____

Facility Address: _____

List past experience in the working with the storage and handling of medical gases. *(Use additional sheets if necessary.)*

CLASS E: DURABLE MEDICAL EQUIPMENT

Laboratory Director Name: _____

Lab Director Address: _____

PROTOCOL: Describe where durable medical equipment will be stored, used, and accounted for. *(Use additional sheets if necessary.)*

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PHARMACY QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. _____ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
3. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign or surrender a license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
4. _____ Is any facility, owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant currently under investigation or is any disciplinary action pending against such now by any licensing agency or governmental agency?
5. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
6. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
7. _____ Is any action related to the conduct or patient care of any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant pending at any hospital or health care facility?

(Continued on the next page.)

8. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
9. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
10. _____ Is any action pending against any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
11. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
12. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to surrender a registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
13. _____ Is any action now pending against any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
14. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant been named as a defendant in a malpractice suit?

(Continued on the next page.)

15. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
16. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
17. _____ If you are licensed in the occupation/profession for which you are applying, would any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant pose a direct threat to himself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
18. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
19. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been terminated from a position because of drug use or abuse?
20. _____ Is any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever currently using or has any recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
21. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which he has not successfully completed or is not now participating in a supervised drug rehabilitation program, or for which he has not otherwise been successfully rehabilitated?
22. _____ Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had a documented case in which he was involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?

(Continued on the next page.)

23. _____ Do you currently have any criminal action pending?
24. _____ Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
25. _____ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
26. _____ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea in abeyance or deferred sentence*)?
27. _____ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



If you answered “yes” to questions 23, 24, 25, 26, or 27 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.



If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

A “yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for inspection by the public, except with regard to the release of information which is classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Responsible Party: _____

Date of Signature: ____/____/____

Printed Name of Responsible Party: _____

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CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To be completed by the pharmacist-in-charge of all in-state and out-of-state pharmaceutical facilities that dispense controlled substances in Utah **to any person** other than an inpatient in a licensed health care facility.

Pharmacist-In-Charge: _____

Pharmacy Name: _____

Pharmacy Address: _____

Telephone: _____ Fax: _____

Email: _____

Type of Pharmacy: _____

Software Vendor:

☐ Foundation

☐ NDC

☐ PDX

☐ ZADALL

☐ 3PM/McKesson

☐ Other, _____

NABP Number: _____

Anticipated Date of Beginning Operation: _____

Check “**Yes**” or “**No**.”

☐ Yes ☐ No I am the pharmacist-in-charge of the above named pharmaceutical facility.

☐ Yes ☐ No I will submit all required data regarding every prescription for a controlled substance dispensed in Utah by me and all pharmacists under my supervision to any person other than an inpatient in a licensed health care facility in accordance with Section 58-37-7.5 of the Utah Controlled Substances Act.

☐ Yes ☐ No I have read and understand Section 58-37-7.5 of the Utah Controlled Substances Act.

Signature of Pharmacist-In-Charge: _____ Date: ____/____/____

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NEW OPENING - PHARMACY SELF-INSPECTION REPORT

CLASS "A" (RETAIL) PHARMACIES ONLY

This report and Class "A" pharmacy application should not be submitted to DOPL until the facility is substantially completed and is within six weeks of the anticipated date of opening.

Please print clearly or type information.

Pharmacy Name: _____ Date: _____

Telephone: _____ Pharmacy Fax: _____

Hours (Monday-Friday): _____ Saturday: _____ Sunday: _____

Full Address: _____

Pharmacist-in-Charge: _____

Pharmacist-in-Charge License Number: _____ Expiration Date: _____

Anticipated Date of Pharmacy Opening: _____

Please review the Pharmacy Practice Act and Rules, Utah Controlled Substances Act and Rules, and the Code of Federal Regulations for all issues related to the practice of pharmacy.

The following questions should be answered in regards to your knowledge and intent to comply with pharmacy and controlled substance law and rule – prior to opening your pharmacy.

- | | Yes | No | N/A | |
|----|--------------------------|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If the facility desires to have a pharmacy technician training program, prior to beginning any training, the program will be submitted and will receive approval by the Division in collaboration with the Board. |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | All individuals employed in the pharmacy facility will be properly licensed or in an approved training program. |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will post the license of the facility and the license or a copy of the license of each pharmacist, pharmacy intern, and pharmacy technician who is employed in the facility. |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | All pharmacy personnel having any contact with the public or patients receiving services from that pharmacy facility will wear on their person a clearly visible and readable identification showing the individual's name and position. |

(Continued on the next page.)

- | | Yes | No | N/A | |
|-----|--------------------------|--------------------------|--------------------------|---|
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The offer to counsel will be documented, and documentation will be available to the Division. |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will have a counseling area to allow for confidential patient counseling. |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The dispensing area will have a sink with hot and cold culinary water separate and apart from any restroom facilities. |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will be stocked with the quality and quantity of product necessary to meet its scope of practice in a manner consistent with the public health, safety and welfare. |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will be is equipped to permit the orderly storage of prescription drugs and devices in a manner to permit clear identification, separation and easy retrieval of products and an environment necessary to maintain the integrity of the product inventory. |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The temperature of the pharmacy will be maintained within a range compatible with the proper storage of the drugs and said documentation will be available to the Division. |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The temperature of the refrigerator and freezer will be maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing and said documentation will be available to the Division. |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will be equipped with a security system to permit detection of entry at all times when the facility is closed. |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If the pharmacy will be located within a larger facility such as a grocery or department store, proper measures will be taken to secure and lock the pharmacy in such a way as to bar entry to the public or any non-pharmacy personnel when the pharmacy is closed. |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If the facility includes a drop/false ceiling (<i>i.e. solid walls do not extend to the roof of the structure</i>) measures have been taken to prevent entry into the pharmacy via the drop/false ceiling. |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will have current and retrievable editions of the following reference publications in print or electronic format and readily available and retrievable to facility personnel: DOPL Licensing Act and Rules; Pharmacy Practice Act and Rules; Controlled Substance Act and Rules; Code of Federal Regulations; FDA Approved Drug Products (Orange Book); and General Drug References. |

(Continued on the next page.)

- | | Yes | No | N/A | |
|-----|--------------------------|--------------------------|--------------------------|---|
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility will maintain a permanent log of the initials or identification codes which identify each dispensing pharmacist by name. The initials or identification codes shall be unique to ensure that each pharmacist can be identified. |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | A beginning inventory will be conducted prior to the pharmacy opening. An annual inventory will be conducted every 12 months, following the initial inventory, and may be taken within four days of the specified inventory date each year. |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Child-resistant containers will be available for use when dispensing medications to patients. |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Each drug dispensed from the pharmacy will have a label securely affixed to the container indicating the required minimum information, including the beyond use date. |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prescription forms and records of all controlled substances listed in Schedule II will be maintained separately from Schedules III through V, which will be maintained separately from all other facility records. All records will be maintained by licensee for a period of five (5) years. |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Information will be submitted to the Controlled Substance Database, as required, with proper documentation kept on site. Positive identification of the person receiving each controlled substance prescription, including the type of identification and any identifying numbers on the card will be obtained and submitted to the manager of the controlled substance database. |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | The facility is not affiliated with and does not dispense prescription medications for internet pharmacy sites or third party processors unless authorized to do so. |

I understand that it is unlawful and punishable as a Class A Misdemeanor to apply for or obtain a license or to otherwise deal with the Utah Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement or omission.

____/____/____
Date

Signature of Pharmacist-in-Charge